North Carolina Mental Health Planning and Advisory Council
October 4, 2007
10:00am-3:00pm
Approved as Revised per November 2, 2007

Members Present: Jeff McLoud, Emily Moore, Vendia Currie, Tisha O'Neal Gamboa, Gail Cormier, Katie Sawyer, Mark Urban, Rick Zechman (for Esther High) - Division of Social Services, Mary Edwards, Dorothy Best, Beverly Varner, Lucy Dorsey – Sandhills Local Management Entity, Sheila Wall-Hill, Vice Chair, Kelly Graves (for Terri Shelton) – UNC Greensboro, Jim Swain (for Dan Fox) - Division of Vocational Rehabilitation Services, Carolyn Wiser, Division of Medical Assistance, Amy Smiley (for Laura White) - Division of Mental Health, Developmental Disabilities & Substance Abuse Services), Kelly Jones Nguyen, Powerful Youth, and Loretta King (by phone).

Others Present:
Martin Pharr, Dept. of Juvenile Justice and Delinquency Prevention (DJJDP), Libby Jones, NC Families United

Staff Present: Lisa Jackson, Adult Planner, Susan E. Robinson, Child Planner, Dr. Maria Fernandez and Nidu Menon, Quality Management Team, Kelly Crowley, System of Care Coordinator

Welcome, Introductions and Approval of August Minutes
Chair, Jeff McLoud called the meeting to order at 10:15am. Jeff offered regrets from members who were not able to attend this meeting and welcomed those who serving as designees. Everyone was welcomed. With a quorum present, the minutes were reviewed and approved. First motion to accept given by

Implementation Report Review of Data Systems and the Data Trends for the Implementation Report of the SFY07 Plan
Jeff welcomed and introduced Nidu Menon, Quality Management Team and Deborah Merrill, Data Management Team. By way of introduction, Jeff stated that both these Division of MHDDSAS Teams provide data for including in both the block grant plans and reports.

Nidu provided a power point presentation and corresponding handout. Nidu summarized transformation from the federal and state perspectives, reviewed the state plan priorities. Sample format of data analysis reports were reviewed. Results of both the NC TOPPS and Consumer Satisfaction Survey responses were reviewed and what we can learn from the trends over time (past three years). These were noted for both adults and children/youth. Council members discussed the value of being able to better understand who is getting what service, how much service, the dose/intensity, and over what period of time, the frequency.

Areas identified for future review included specific questions about provider choice as the results seem to indicate that adults don't seem to think they have choice of providers from those who responded to the survey. One concern raised related to this was the consumer choice voice through person centered planning does not get written as the options discussed for in the plan. Many consumers need self-advocacy skills and a better understanding of provider choice, the

process and plan. It was noted that this finding is different for children and youth/families, in that they report
feeling there is choice for services and being satisfied with those services with improved outcomes/functioning reported.

The Consumer Satisfaction is administered annually with consumers and families/youth during a point in time (2 weeks) in October through the LMEs and providers. A 6000-7000 return rate is considered very good for this type of sampling.

Discussion regarding Evidenced based practices, how defined, what is available in NC, and how reported for the block grant. State Operated Services Team gets information through the HEARTS data. Most state operated hospitals are at peak usage presently according to the data collected. Readmission rates are not changing much over time.

Discussion regarding the NCTOPPS which has been used for tracking outcomes since 2003; this is a longitudinal tracking system. It is done at 3 month intervals. There is a wide variation in LMEs using this from 11% to 90% compliance. This will continue to be addressed with LMEs, providers in performance reporting and peer to peer comparisons. In domain 4, families report that impaired family relations are major problems. It is important to note that family relationships are seen as a problem by family members themselves, this is not necessarily a reflection of a failed mental health system. Council members agreed and discussed the response as reasonable, that indeed they are stressed.

Nidu and Ging reported on a recent conference held by the Quality Management Team with all LMEs bringing teams to the conference, with more than half those attending being consumers/families as key team members. This was done purposefully in response to Council members indicating the need to assure consumer/family role in evaluation locally as well as at the state level.

System management of funding for designated populations for a specific age or ability. Members raised concern that with the new state legislation that more LMEs will become single stream funding and monitoring their expenditures for services to high need populations will not occur as a result. Methods for looking at this need to be in place.

Nidu addressed proposed changes in methodology? Among the changes considered are making the survey anonymous, self-administered and a longer submission time (not just a 2 wk time period, perhaps year round. Providers need to participate for this system to be effective and reach all consumers in service during the time of the survey. This may become part of an incentive to keep the funding for the services. Changing how it is administered, will address the consumers concern for confidentiality and increasing provider return rates. Nidu asked the Council to discuss this in future meetings and make recommendations to the QM Team.

Deborah Merrill provided a power point presentation and corresponding handouts on how we collect data. Nidu's focus was on how the date is put into reports. The data reviewed followed the indicators and measures required by the MHBG for planning and reporting purposes. The number of different sources of data are kept in the client data warehouse (CDW). This data includes, numbers served, location served, demographics of those served, Clinical data examples include ICD-9 diagnoses – an international diagnosis standard worldwide classification of

diseases; GAF global assessment functioning score is collected at admission and discharge and the Oryx data base.

Population groups served in the community, primarily for federal funds (severe and persistent mental illness and serious mental health needs of children/youth). IPRS is a service event data collection system, not services per individual level.

MHSIP—our survey is used in 40 other states. This has been updated over time to stay current. It has gone through reliability and validity studies. There may be 4 or 5 question s in each domain. It is a 5 point scale rated on a continuum from high to low.

Social connectedness is a new domain that we are measuring. Self assessment of outcomes—Thirty questions go into making up these domains. USR is the uniform reporting system; every state reports data to SAMHSA; standard table; on Dec 1st these tables are sent in as part of our state's block grant report. NC is becoming a more diverse populated state. URS tables-need to have data broken out by race, ethnicity, etc. IF providers follow our rules, they shouldn't know how consumers answer the survey. The consumer is supposed to go to a private room, complete the survey, fill it out and put in a lock box. They are not to be copied by the provider or LME. LMEs and providers get a data file back but there is no identifying information. Different approach to collecting this survey information is being used this year; the LMEs are to pick up the surveys from the providers' locked box and then will send to the Division for scanning/entry.

Some states have a totally consumer-driven survey system, but this is costly (Louisiana, Clients interview other clients). Our numbers are in line with other states, even with states that have self-administered surveys. Consumers want to please providers. Across the whole US the feeling is that responses are too positive. There are directions on the survey that are clear and protect confidentiality. Durham Center went to great lengths to get consumers involved in administering surveys but was not able to pay them, so they had to be volunteers. This survey is a requirement of the MHBG and the URStables.

The Division is looking at a web based application of the survey. This is maybe something the Council focus groups can look at in the spring.

One member indicated, that she felt more comfortable completing the form in the provider's office rather than done over the phone as this had been done at one time.

Prior to Karen leaving, she reminded the Council that October is Disability Awareness Month. In addition, it is also Domestic Violence Awareness Month.

Jeff and the Council thanked presenters.

~ Lunch
The meeting reconvened at 1 with committee meetings.

Committees met and reported to the full Council. Each committee reported additional comments based on the morning discussions and information presented. In addition recommendations, significant achievements and needs were identified that will be included in the report as well as

considered for future meetings in January, March and May 2008. The following are the committee recommendations for Council Priority Areas of Focus during this FFY 08 Plan year.

Adult Committee: Priorities for the next year for the adult committee recommendations to the Council and the Division of MHDDSAS are listed below (not in priority order):

- Priority #1 – **Education/Training**: To increase education/training for consumers and family members as well as for providers/direct care/support staff. (Criterion V. Management Systems)
- Priority #2 – **Evidence-Based Practices** (EBPs): To support the development of EBPs that focus on jail diversion, after care practices on a post incarceration basis, services to older adults with mental illness, and services that support Peer Specialists. (Criterion I. Community Based System, Criterion II. Data Epidemiology and Criterion III. Children's Services)
- Priority #3 – **Housing**: To increase the number of safe, affordable housing options for people with mental illness. (Criterion IV. Rural and Homeless and Criterion I. Community Based System)
- Priority #4 – **Recovery**: To increase systematic support for the concept of recovery across the whole service delivery system. (Criterion I. Community Based System and Criterion III. Children's Services)

Child and Family Committee: Priorities for the next year for the child and family committee recommendations to the Council and the Division of MHDDSAS are listed below in priority order.

- Priority #1 **– Sustain Transformation through implementation of the essential components of a System of Care (SOC) approach:** To sustain and build systematic support for the essential components of SOC across the whole service delivery system. Especially in the implementation of child and family teams as a vehicle for person centered planning that is culturally responsive, outcomes driven and is guided by family and youth centered practice. (Criterion V. Management System, Criterion I. Community Based System and Criterion III. Children's Services)
- Priority #2 **– Workforce Development:** To for provider capacity and quality of care delivered. (Criterion V. Management System, Criterion I. Community Based System and Criterion III. Children's Services)
- Priority #3 **– Consumer, Family and Youth Involvement:** To increase and sustain consumer, family and youth involvement in workforce development at all levels, as developers, trainers, participants at the state, regional and community levels. In particular, helping families learn how to choose a provider and helping providers understanding informed consent and decision-making. (Criterion V. Management System, Criterion I. Community Based System and Criterion III. Children's Services)
- Priority #4 **– Evidenced Based Practices and Practice Based Evidence:** To support the development of peer support for family and youth, especially those in youth in transition and/or homeless (especially under McKinney Vento, IDEA and ADA) working with schools on behalf of their school age children and with families of preschool age children. (Criterion V. Management System, Criterion IV. Rural and Homeless, Criterion I. Community Based System, Criterion II. Data Epidemiology and Criterion III. Children's Services)

Council Project Discussion - Focus Group Proposal

Jeff outlined the proposal he offered at the meeting in August for follow-up discussion. He stated that funding will be used primarily for travel reimbursements for Council members to conduct the focus groups in the Western, Central and Eastern regions. Jeff indicated he had volunteers for Council facilitators for each site. In addition, thanked UNC-Greensboro (Terri Shelton, Kelly Graves) for offering on-site assistance or any logistical assist needed for these focus groups as well. Jeff asked for additional volunteers for the task group. Tisha, Kelly, Gail and Dorothy volunteered to help along with Stan. Jeff asked for member agreement to proceed with this effort in the Spring 2008. Jeff stated that Lisa and Susan would be staff to these events and support Council members' participation as needed.

~Member Updates

Information and activities were shared with the group. In particular, Esther High, DSS, is retiring and there will be a new DSS representative participating soon. Dan Fox, is also retiring, with a new representative from DVR attending soon.

Wrap-Up

Reimbursement forms were distributed and collected mileage. Jeff thanked everyone for their participation and adjourned the meeting. Jeff indicated there would be no meeting in September and the next meeting would be on October 5 at the same place and location. Sheila Wall Hill moved to adjourn at 3:10, with a second received, and all voting affirmatively.